Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Ved V. Aggarwal M.D. 914 Lipscomb Ft Worth, TX 76104	MFDR Tracking #: M4-04-7464-01
Respondent Name and Box #: American Casualty Company of Reading, PA Rep. Box #: 47	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Carrier has denied these services as global to the implantation of the SCS electrodes. This is not supported by the CCI edits and should be reimbursed."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $237.84
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Provider seeks additional reimbursement for CPT Code 95972 (electron analysis/programming) and CPT Code 76005 (fluoroscopy). These charges were denied by Carrier citing, "G – unbundling," as these charges are global to the charge for the implantation of the neurostimulators (CPT Codes 65650)."

Principal Documentation:

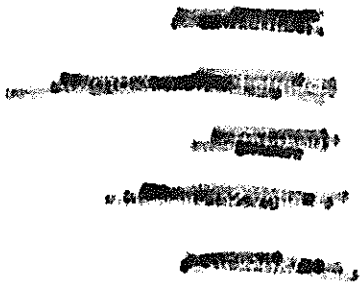
1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
10/28/03	95972	NO EOB	2, 4, 5	$102.88
10/28/03	76005-26	G, O	1, 3	$0.00
Total Due:				$102.88

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.



1. These services were denied by the Respondent with reason code "G – DENIED PER INSURANCE: SERVICE IS INCLUDED IN THE GLOBAL VALUE OF ANOTHER BILLED SERVICE. 100%." and "O – IN RESPONSE TO A PROVIDER INQUIRY, WE HAVE RE-ANALYZED THIS BILL AND ARRIVED AT THE SAME RECOMMENDED ALLOWANCE."
2. Requestor submitted CPT code 95972 on original billing and on request for reconsideration billing. Respondent recoded the valid CPT code 95972 to CPT 95999 for same service and denied it as global on both original and reconsideration EOBS. CPT 95972 is not global to the 63650 CPT codes billed on same day, therefore, reimbursement is recommended per Rule 134.202.
3. CPT code 76005-26 was denied as Global to CPT codes 63650. The Respondent audit is correct and no reimbursement is recommended for this procedure per Rule 134.202.
4. CPT code 95972 has a MAR of $102.88 ($82.30 x 125%) due Requestor per Rule 134.202.
5. Per review of Box 32 on CMS-1500, zip code 76104 is located in Tarrant County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

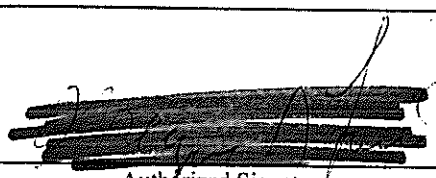
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $102.88 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:



Authorized Signature

Medical Fee Dispute Resolution Officer

01/18/08
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.